Technical Report No. 27

Assessment of Third Party Payers in Jordan

October 1998

Prepared by:

Neil Hollander, M.S.
Consultant
Abt Associates Inc.

Margie Rauch, M.P.I.A., M.H.S.
Consultant
Abt Associates Inc.

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:

Development Associates, Inc. ■ Harvard School of Public Health ■
Howard University International Affairs Center ■ University Research Company LLC

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *better informed and more participatory policy processes in health sector reform;*
- *more equitable and sustainable health financing systems;*
- *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *improved organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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and Robert Emrey, COTR
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Abstract

The Partnerships for Health Reform, funded by the United States Agency for International Development, provides technical assistance in a variety of areas—including universal coverage of health services—to help improve the efficiency, effectiveness, and equity of Jordan's health system. This report outlines the findings of the assessment, conducted in June 1998, of private third party payers in the health sector and the potential roles they could play in a universal health system. The report also presents a brief overview of Jordan's health sector, quantitive data on third party payers, their organizational structure and business/service approach and plans.

The report contains a list of short- and long-term recommendations on actions to take in order to determine the roles of private insurance and to enable third party payers to contribute to social health insurance.

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Acronyms

CIP	Civil Insurance Program
GDP	Gross Domestic Product
JD	Jordanian Dinar
JUH	Jordan University Hospital
MENA	Middle East and North African
MIT	Ministry of Industry and Trade
MLR	Medical Loss Ratio
MOHHC	Ministry of Health and Health Care
OECD	Organization for Economic Cooperation and Development
PHR	Partnerships for Health Reform Project
RMS	Royal Medical Services
TPA	Third Party Administrator
UNRWA	United Nations Relief Works Agency
USAID	United States Agency for International Development

Acknowledgments

We would like to thank all the people that we interviewed during our visit. They generously gave us their time and provided the information needed to write this report. With the spirit of cooperation that was shown to us by these public and private sector participants in Jordan's health system, we are hopeful that skills and resources from both sectors can be combined to achieve the desired improvements in the health care system.

Executive Summary

The Partnerships for Health Reform (PHR) project is providing technical assistance to the Jordanian Ministry of Health and Health Care (MOHHC) of the Hashemite Kingdom of Jordan, and to other Jordanian counterparts in a wide variety of activities aiming to improve the efficiency, effectiveness, and equity of Jordan's health system. One of the most important issues for which PHR is providing technical assistance is universal coverage of health services, a goal to which Jordan has committed itself. In June 1998, PHR assessed private third party payers in the health sector and the potential role they could play in a universal health system. The purpose of this technical report is to describe Jordan's private health financing sector and analyze the capacities and the options for this sector to contribute to universal health insurance.

Jordan is a small country of 4.6 million people (1997) with per capita gross domestic product of $1,700, making it a middle-income country. The health care delivery sector is composed of the public sector, private sector, and international and charitable sector. The public sector dominates the delivery of health care through the MOHHC, the Royal Medical Services (RMS), and Jordan University Hospital (JUH), which operate independently. The public sector is also the primary source of health insurance coverage (up to 68%), with the private sector covering an estimated 8% to 12% of Jordanians. However, financing of health services may be dominated by the private sector which pays for an estimated 53% of total health expenditures.

The private health-financing sector comprises private insurance companies, self-insured firms, and third party administrators (TPA). Twenty firms offer health insurance, and they cover an estimated 138,815 beneficiaries, mostly middle and upper class professionals. Health insurance premiums represent only 12% of all insurance premiums. Insurance executives interviewed did not consider health insurance a highly profitable product. The number of self-insured firms is unknown, but most large employers offer health benefits to their employees. The estimated number of beneficiaries ranges from 390,000 to 650,000. There are only three TPA firms in Jordan. They service 74,300 beneficiaries through contracts with insurance companies and a few self-insured firms.

Private insurers design health insurance policies to contain costs and control risk by excluding many diseases and treatments. Underwriting is typically done on an individual basis using age, sex, and reported medical use. Companies do not typically use professional actuaries or community rating. Only the TPAs and one insurance company have automated systems to review and pay medical claims. Companies do little market research or advertising for health insurance products because few consider health insurance as a growth industry with the potential for significant profits. Most companies sell health insurance policies through insurance brokers or directly to clients. Some companies restrict the number of brokers who can sell health insurance. Many sales are accommodations to existing customers.

Insurance companies and self-insured firms deal primarily with private sector physicians and hospitals. They have used both contractual (insurer pays providers) and indemnification (insurer pays beneficiary) approaches. Contracts with providers are usually simple and primarily define the terms for payment. Private third party payers follow government and professional price controls to pay hospitals and physicians. Recently some third party payers have begun to negotiate with groups of providers to establish provider networks, particularly in Amman where there is an over-supply of private hospital beds and physicians. However, Jordan presently has no integrated delivery system that would unite the provision and financing of care. They conduct utilization review on a case-by-case basis, typically focusing on determination of eligibility or benefits, as opposed to practice patterns or part of a quality

assurance effort. Existing management information systems are rudimentary. Insurance executives are knowledgeable administrators and TPAs are developing further capacity in health insurance, provider management, and claims systems, but many more workers need to be trained.

Third party payers have not organized themselves to manage government relations in a coordinated manner. Instead, each company deals with the government independently. What regulation there is, is done by the Ministry of Industry and Trade (MIT) through the Controller of Insurance. Regulation of insurance is minimal, and there is no regulation specific to health insurance. There is little coordination between the MOHHC and the MIT. The Controller's office has proposed new legislation to address some of these issues.

The single most important factor that determines the role of private third party payers in any country's health sector, is the role of the public sector in the financing and delivery of health services. Private third party payers typically evolve in response to the gaps in coverage or the perceived deficiencies of the public health system. Thus, private insurance provides coverage: for people who are ineligible for the public insurance program, for people who withdraw from a public insurance program, and and for people who seek supplemental or additional coverage. In determining a role for private third party payers, policymakers should consider their potential advantages, which includes expertise, flexibility, innovation, capital, credibility, and increased consumer choice. Potential disadvantages include the sector's for-profit orientation, its lack of experience with the poor, and tendency to cover only low-cost people.

Policymakers can pro-actively establish a role for private third party payers through procurement approaches wherein the government contracts with the private sector for insurance risk taking and operational and/or administrative functions. In Jordan, the government could shift to private insurers and/or to TPAs the responsibility for paying providers, containing medical costs, ensuring a minimum level of quality, auditing, utilization management, and standards certification. However, procurement approaches require important capacities in both the public and private sectors. The government must be able to translate policy objectives and programs into clear contracts that spell out requirements and performance standards. The public sector must also have the capacity for performance monitoring and evaluation, and auditing procedures. Given Jordan's limited experience contracting with private insurers, the government will require time to develop the needed these skills and structures. In addition, the private insurance industry in Jordan does not currently have the risk capital and administrative capacity to take on a large role. The industry would need to invest time, materials and money to develop the capacity to respond to public sector procurement efforts.

Regulation is another way that the public sector can determine a role for the private health financing sector in a social insurance system. Regulations generally aim to maintain a stable insurance market, protect consumers, and/or improve local notions of fairness and equity. Beyond these standard objectives of regulation, the government could pass legislation that encourages the private insurance sector to have a specific role in a social insurance system, for example, a regulation allowing private insurers to offer supplementary coverage to basic social insurance program.

In conclusion, the Jordanian government and private third party payers should explore and develop greater collaboration, not only to support social health insurance but also to exploit opportunities to improve the efficiency, effectiveness, equity, and quality of Jordan's health sector. The building of both trust and effective working relationships between the public and private sectors is necessary to prepare the way for future partnerships. On the positive side both the public and private sectors understand that they need each other; they share the same goals of containing medical costs and improving quality; they share the desire to make the country's health sector more equitable; and they share the perception that steps must be taken to change the health delivery system before universal insurance coverage is implemented.

On the negative side, the public and private sectors have little experience working with each other and both need to be develop critical skills and capacities in order to collaborate successfully.

Over the long term, the MIT must improve regulation of the health insurance industry. The private and public sectors need more demographic and health-related actuarial data and new management capacities. Jordan may also explore the possibility of encouraging the establishment of new not-for-profit organizations. In the short term, the government could increase interaction with private sector experts or organizations in health insurance: begin work on improving regulations; undertake joint projects in specific areas to learn how public-private partnerships could work; and support establishment of insurance training programs.

1. Introduction

The Partnerships for Health Reform (PHR) project is providing technical assistance to the Jordanian Ministry of Health and Health Care (MOHHC) and to other Jordanian counterparts in a wide variety of activities aiming to improve the efficiency, effectiveness, and equity of Jordan's health system. The various project activities were originally outlined in a Country Activity Plan, which was jointly developed and approved by PHR, the United States Agency for International Development/Amman, and Jordanian representatives.[1] One of the most important issues for which PHR is providing technical assistance is universal coverage of health services.

The Hashmite Kingdom of Jordan has committed itself to the goal of universal coverage of health services. Policy leaders in Jordan are considering alternative approaches for expanding coverage. At the time of this report, Jordan was still working on defining how expanded coverage would be financed, the scope of benefits to be covered, the target population, and the role of public and private entities. As part of PHR's technical assistance in this area, in June 1998, PHR assessed private third party payers in the health sector and the potential role they could play in a universal health system.[2] Third party payers are private organizations or firms that pay the provider (doctor or hospital) for services rendered to the patient. Third party payers make up the private health-financing sector.

The purpose of this technical report is to describe Jordan's private health-financing sector and analyze the capacities and the options for this sector to contribute to universal health insurance. The report presents a brief overview of Jordan's health sector, quantitative data on third party payers, their organizational structure, business/service approach and plans, and then discusses potential roles for private insurance and financing in a social insurance system. Conclusions and recommendations are presented in the last section.

[1] "PHR Country Activity Plan, Jordan 1998-2000." July 1998.

[2] "PHR Trip Report: Assessment of Third Party Payers in Jordan, June 20-July 10, 1998" by Neil Hollander and Margie Rauch.

2. Background

To understand the private health insurance and financing sector, it is useful to have a broad understanding of the overall system of financing and delivery of health services in Jordan. Therefore, this section presents a brief overview of Jordan, its population and health sector. Much of the data presented in this section are from the 1997 World Bank health sector study of the Hashemite Kingdom of Jordan.

2.1 General

Jordan is a small country of 4.6 million people (1997) with per capita gross domestic product (GDP) of $1,700, making it a middle-income country.[3] The population is relatively well educated with an adult illiteracy rate of only 13% in 1995.[4] Health indicators are also relatively positive, with a life expectancy at birth of 70 years in 1995[5] and an infant mortality rate of 28 per 1,000 live births. However, the population of Jordan is growing. The total fertility rate is 4.4 children per woman of reproductive age and 41% of the population is under the age of 15 years (i.e., entering their prime fertile years). At the same time, declines in the death rate have increased the number of elderly in the population. These factors raise concerns for increasing expenditures on health care.

2.2 Health Care Delivery System

The health care delivery sector is composed of the providers of health care services—hospitals, clinics, physicians, pharmacies, etc. There are three major components of the health care delivery sector: the public sector, private sector, and international and charitable sector. Each sector operates independently.

The **public sector** dominates the delivery of health care in Jordan. It operates 947 primary care health facilities[6] and the majority (70%) of hospital beds, which have an average occupancy rate of 69%.[7] The public health sector is comprised of the MOHHC, the Royal Medical Services (RMS), and Jordan University Hospital (JUH).

In 1994, the **private sector** had 30% of the total beds with an average occupancy rate of 49%.[8] There are also many private clinics (i.e., single or group physician practices) throughout Jordan but with the majority in Amman. Most of the private hospitals and clinics were constructed in the 1990s. This growth—which is continuing—is thought to be a result of a combination of factors: a) the view that Amman would succeed Beirut as a regional medical center; b) the return of many wealthy Jordanians after the 1991 Iraq war who repatriated wealth to Jordan creating a pool of capital looking for attractive investment opportunities; and c) limited government regulation of the private health sector's growth.

[3] July 1998 presentation by a MOHHC official.

[4] World Bank. 1997. "World Development Report 1997: The State in a Changing World." New York: Oxford University Press.

[5] World Development Report 1997.

[6] This figure includes 364 health centers, 274 village clinics and 307 maternity and childhood centers; 1997 Statistical Yearbook, The Hashemite Kingdom of Jordan.

[7] World Bank. 1997 "Hashemite Kingdom of Joran: Health Sector Study." World Bank Country Study. Wash, DC. Page 24.

[8] 1997 World Bank Health Sector Study, p. 20.

The **international and charitable sector** is represented by the United Nations Relief Works Agency (UNRWA) primary health care facilities,[9] which serve more than 40,000 Palestinian refugees, and the facilities of other international and domestic charitable organizations.

There were 7,322 physicians in Jordan in 1996 and 4,304 nurses in 1995.[10] However, since only 69 percent (5,052) of the physicians are licensed to practice medicine in Jordan, there are only 1.14 licensed physicians per 1,000 persons. While this physician/population ratio is much lower than that found in OECD countries, which average 2.5 physicians per 1,000 persons, it is much higher than the average of .8 per 1,000 for the Middle East and North African (MENA) region.[11] There are high utilization rates for primary care (1.6 visits per capita, per year). Jordan has 1.6 hospital beds per 1,000, which is equal to the MENA average and lower than either OECD countries (8.3 beds per 1,000) or the United States (4.4 beds per 1,000).

In sum, for a population of 4.6 million Jordanians, there appears to be significant medical service provision capacity.

2.3 Health Care Coverage

Most Jordanians—68% according to the World Bank—have public sector health care coverage through either the Civil Insurance Program (CIP), for civil servants; the RMS, for military personnel; or other public programs. Private insurance covers 8 to 12 percent of Jordanians. Many people are eligible for more than one type of coverage. Estimates of the percentage of Jordanians without any health insurance, called the "uninsured," vary from 20 to 47 percent. The uninsured can purchase health services at the MOHHC at highly subsidized prices. Table 1 shows estimates for the major sources of health care coverage in Jordan from two recent sources. PHR will conduct a household health survey that should provide more precise data.

Table 1: Estimates of Health Insurance Coverage in Jordan Percent (%) of Jordanians

Source of Health Coverage	Jordan Living Conditions Survey[12]	World Bank Health Sector Study
Royal Medical Services	45	35
Civil Insurance Program	39	23
JUH/UNRWA/other public	7.5	10
Private Sector	8	12
Uninsured	47	20
Total	146.5	100

[9] UNRWA's proposed health program budget in 1994-95 was $22.6 million according to a March 1995 World Bank-funded study by a team of consultants at the University of Jordan.

[10] Jordan National Information System

[11] 1997 World Bank Jordan Health Sector Study, page 16.

[12] Jordan Living Conditions Survey, 1996, Main Results, October 1997. The Hashemite Kingdom of Jordan Department of Statistics and the Institute for Applied Social Science of Norway.

2.4 Health Care Expenditures

Jordan spends a relatively large amount on health care: 7.9% of gross domestic product in 1994.[13] The estimated breakdown of expenditures by source of payment was 47% from the public sector and 53% from the private sector in 1994.[14] This contrasts with the previously discussed breakdown for health insurance coverage of 68% public sector and at least 8-12% private sector (with an estimated 20% uninsured).

In 1997, about 5.6% of the national budget—approximately JD106.8 million, or US$151 million[15]—was spent on MOHHC activities.[16] This worked out to JD 23.2 (US$32.80) per person for the entire population.[17]

Private sector expenditures include expenditures by people with private commercial insurance, expenditures by self-insured companies that directly pay for health services for their employees, and by people who have public coverage but who choose to pay out-of-pocket for private health care. Private health expenditures in 1994 were estimated to be JD 177 (US$250) million or JD 43.81 (US$61,88) per person for the whole population.

The estimated breakdown of total health expenditures by type of service in 1994 was 36% on inpatient hospital care, 27% on ambulatory care, 27% on pharmaceuticals, and 10% on other health expenditures. Spending on pharmaceuticals is high compared to OECD countries, for which the average is only 14%, but consistent with other MENA countries, such as Turkey and Egypt. Generally drugs are in short supply in the public sector, so people often turn to the private sector to get prescriptions filled. In fact, it is estimated that the private sector is the source for 85% of total spending on pharmaceuticals[18].

In summary, Jordan overall spends a substantial portion of its national income on health care. The public sector spends a substantial share of the national budget on health care. Private sources fund an even larger share of health care expenditure than the public sector, with much of the expenditures reportedly on pharmaceuticals. In this context, Jordan is pursuing health sector reform to increase efficiency and explore universal health insurance.

[13] 1997 World Bank Jordan Health Sector Study, page 13.

[14] 1997 World Bank Jordan Health Sector Study, page 61.

[15] JD = Jordanian Dinars, exchange rate of JD 0.707 / US$1.

[16] MOHHC document, schedule 29-1.

[17] Taking the MOHHC budget figure of 106,819,000 JD in 1997 and dividing by a 4.6 million population, the average amount budgeted per capita was 23.22 JD.

[18] 1997 World Bank Jordan Health Sector Study, pages 14 and 61.

3. Methodology

A two-person PHR team (Neil Hollander, health finance advisor, and Margie Rauch, health economics analyst) used an oral survey method to collect information on third party payers in Jordan. The team prepared detailed interview guides and interviewed more than 25 key participants in Jordan's private health insurance and financing system. Institutions interviewed included two public hospitals, Jordan University Hospital, four private hospitals, the Ministry of Trade and Industry (Insurance Controller's Office), private insurance companies, third party administrators (TPAs), self-insured firms, the Royal Medical Services, and the Ministry of Health and Health Care. The team also collected quantitative data from the Insurance Controller's Office, the insurance companies, TPAs, self-insured firms, the RMS, and the MOHHC.

4. Third Party Payer Sector: Quantitative Data

This section gives the reader a primarily quantitative overview of the private health-financing sector. More qualitative information, describing the private sector's organizational structure and business/service approaches, is provided in section 5.

4.1 Definitions

Three different types of companies or third party payers comprise the private health-financing sector in Jordan:

Private insurance companies: Insurance companies enroll people into a health plan, collect premiums from them, and pay for the medical costs that are covered under the health plan. People enrolled in the plan are called the insured or subscribers or beneficiaries. The insurance companies take the risk that the premiums they charge and collect from the subscribers will be sufficient to cover the costs of the plan and provide the desired profit. Health plan costs include medical costs (also called medical claims costs), plus the cost of administering the health plan and keeping financial reserves.

Self-insured firms: Some private companies, such as an airline or industrial firm, directly pay for health services for their employees and covered dependents. The claims processing may be done by another company, but the self-insured firm pays the providers and takes all of the financial risk inherent in giving their employees and covered dependents access to the covered health services.

Third party administrator firms: TPA firms provide medical claims processing services (including utilization review such as pre-hospital admittance review) to insurance companies or self-insured companies for a fee. The TPAs do not assume any financial risk vis-à-vis the cost of the insured's medical care. In Jordan, the TPAs do not actually pay the health care providers, but inform the client insurance company or self-insured firm what they think it should pay the provider under the terms of the policy.

Quantitative information about the size and finances of each of the three types of third party payers is presented below.

4.2 Private Insurance

4.2.1 Size

Jordan's health insurance industry is small but growing. Of the 26 companies licensed to sell any type of insurance in Jordan in 1998,[19] 20 were licensed to sell health insurance and 18 were actually

[19] Jordan Insurance Company.

selling it.[20] The estimated number of people covered by privately purchased health insurance policies in Jordan has grown from 24,000[21] in 1989 to 138,815[22] in 1997.

4.2.2 Premium Revenue and Profitability

In 1997, the premium revenue for health insurance in Jordan was almost about JD 11.5 ($16.2) million—of total (all types) insurance premiums collected, about JD 96.4 ($136.2) million.[23]

Also in 1997, the profits of the overall insurance industry were about JD 4.7 ($6.6) million.[24] Several insurance executives stated that the life insurance lines were profitable but their health insurance lines were only marginally profitable.

Unfortunately, PHR did not have access to the financial statements of the insurance companies in order to report actual profits or losses. However, the insurance companies did share data on the medical claims and administrative costs for their health insurance plans. These data can indicate whether the plan has the potential to contribute to the insurance company's profits or losses.

The cost of medical services is usually the largest cost of a health insurance plan. The cost of medical claims is often expressed as the medical loss ratio (MLR). A plan's MLR equals it medical claims paid out divided by premiums collected.[25] A MLR over 100% means that the cost of medical claims exceeded premiums collected and that the health plan may have lost money during the period. The MLRs reported by 16 of the Jordanian companies for 1997 ranged from 56% to 167%. (Specific percentages were 56%, 66%, 75% [two companies], 79% [two companies], 83%, 89%, 93%, 98%, 107%, 110%, 115%, 124%, 127% and 167%). Hence, it appears that approximately 38% of the firms surveyed incurred losses on their health insurance plans in the period studied. The average MLR for the industry was 96.6% while the average weighted by each company's share of total beneficiaries was 97.7%.

After subtracting medical claims from the premiums collected, the administrative costs and the allowance for financial reserves must also be subtracted. The administrative costs reported by 15 insurance companies as a percentage of the health insurance premium revenues ranged from 7.9% to 22%. These administrative costs were for health insurance plans only.

The cost data reported above would indicate that health insurance plans do not contribute much to the profits of most of the insurance companies. However, since health insurance is a small part (12%) of the industry, the effect on overall profitability is limited. This is consistent with the statements of several insurance executives: that they make money off their life insurance and other lines of business and sell health insurance only as a courtesy to the clients who want health coverage. Of the 17 companies that reported data on their health insurance lines to the insurance controller, six did not declare anything about their profits, while 11 did. Seven of these 11 companies reported losing money or zero profits on their health insurance lines while only four companies reported profits.

[20] Ministry of Industry and Trade.

[21] "Financing the Health Sector's Rehabilitation in Jordan," by G. Ellena and A. Preker, Oct. 1989, which reported that Alico Insurance company had 12,000 persons enrolled in their health plan and claimed to control 50-60% of third party underwriting for health insurance plans.

[22] Total subscribers as reported by 17 companies to the Insurance Controller's Office.

[23] Total health insurance premium revenue is from the premium numbers reported to the Insurance Controller by the insurance companies. Total insurance premium revenue was reported by the Jordan Insurance Company. Both figures are for 1997, but authors were not able to confirm that data reflected calender 1997 in all cases, as opposed to fiscal year 1997.

[24] Jordan Insurance Company.

[25] The companies provided the Insurance Controller (who provided us) with the figures for the total premiums collected in 1997 as well as the total claims paid out. With these two figures we calculated the medical loss ratios by putting the claims figure over the premiums figure. These ratios were multiplied by 100 so they could be presented in percentage terms.

4.2.3 Health Insurance Costs

The cost of health insurance can be analyzed by the premium rate[26] and the medical claims paid out.[27] Most insurance companies in Jordan offer only a **limited** health insurance policy, which can cover hospital care, or both hospital and outpatient care, but with limits on how much the insurance company will pay out (e.g., per beneficiary per year for surgery, hospital stays, drugs, etc.). Companies reported the following for premium rates and claims paid out:

- average annual premium per beneficiary in the range of JD 51 to 155 ($72–219) (with 17 companies reporting[28])
- unweighted average annual premium per beneficiary: JD 89.56 ($126.50) (17 companies reporting)
- average annual claims paid out per beneficiary in the range of JD 56 to 128 ($79–181) (15 companies reporting)
- unweighted average annual claims paid out per beneficiary: JD 85.36 ($120.56) (15 companies reporting)

In contrast, the premium for a **full coverage**[29] health plan per year for a 5–6 person family with a middle-age male head of household was about JD 1,000–1,200 ($1,412–$1,695). Only one insurance company offered a health policy approaching full coverage. For this health policy the average premium per beneficiary reported by the company was JD 613 (US$866).[30] [31]

4.3 Self-Insured Firms

4.3.1 Size

It is difficult to estimate the number of people (employees plus dependents) who currently have health benefits through their employers; this assessment estimates a range of 390,000 to 650,000.[32] Many of the large companies, both wholly and partially private, and the financial service companies (such as banks) are self-insured. Five of the self-insured firms (Royal Jordanian Airlines, Jordan Petroleum, Jordan Phosphate, the Electric Company, and the Housing Bank) cover 92,500 people. In addition, some people get health benefits through medium-size firms as well as professional trade associations that collect premiums and pay the medical claims for their association members. For example, three professional

[26] I.e., the fixed amount charged per year by the insurance company.

[27] I.e., the medical bills that the insurance company must pay for the beneficiary each year.

[28] Data for the eighteenth company selling health insurance in Jordan were not included in these calculations because that company in 1997 had its health insurance business set up in such a way that the financial risk was taken in Lebanon and not in Jordan.

[29] Full coverage means that inpatient (hospital), outpatient care, and possibly even dental care are covered without strict limits on the amount of treatment. This means that the insurer is at greater risk for high cost treatment.

[30] Interview with executives from the insurance company offering that health policy which they began selling in May 1998. Full coverage means both hospital and inpatient care are covered with only a few limits on how much the insurance company is liable to pay out.

[31] The discrepancy in the expected cost of approximately JD 200 per family member based on the JD 1,000–1,200 per family example versus the actual approximately 600 JD premium per beneficiary may be partly due to the characteristics of those purchasing these policies. They may be mainly older people with a small number of family members covered under their policies.

[32] This estimate is based on the following: the lower range is based on World Bank figures (1997 Health Sector Report). The World Bank estimated that 12% of the population (approx. 490,000 people) had private health coverage. If we take this 490,000 and delete about 100,000 (our estimate of those who had privately purchased health insurance plans in 1994) that leaves the self-insureds at roughly 390,000 people. Given economic difficulties in Jordan, we cannot assume any increase in the number of self-insureds over the period 1994–98, so we can leave this estimate at 390,000. The upper range (650,000 figure) is based on estimates of 600,000 and 700,000 from two executives, one from a TPA firm and the other from an insurance company.

associations cover 13,500 people: 5,000 doctors through the Jordan Medical Society, 6,000 under the lawyers' plan, and 2,500 under the engineers' plan.

PHR is conducting a telephone survey of all 192 firms listed on the Jordanian stock exchange regarding health benefits. This research should yield a more accurate and complete picture of the self-insured market.

4.3.2 Estimated Costs of Coverage

Cost data was collected from five large self-insured firms (Royal Jordanian airlines, Jordan Petroleum, Jordan Phosphate, the Electric Company and the Housing Bank) which combined cover about 92,500 people with full health benefits. The companies did not have separate cost data for medical service and administrative costs, so comparisons with the cost data presented for insurance companies may not be valid. Also, the cost data does not take into account any employee payments for deductibles or co-payments. (The companies indicated that employee contributions were usually only a small share.)

For the group of five companies, the annual health care costs per person ranged from JD 55 to 131 ($78–185) and the average per person cost (weighted by each company's share of covered lives) for these five companies combined was JD 104.31 ($147.33). The self-insured firms seem to offer more extensive coverage than the insurance companies because they do not put limits (or "caps") on the amounts they will pay out for health benefits (e.g., a limit for surgery or medicines per subscriber per year). In contrast, insurance companies use such caps extensively (see section 5.1, "Benefits Design").

Company managers reported concern that some employees make unnecessary use of their hospitalization benefits as a means of returning to Amman to see their families. At least one parastatal company has documented individual cases of this, had a TPA analyze sick leave in order to find patterns of misuse, and sent healthy people to suspect providers to detect unnecessary treatment. However, no publicly available research documents the scope of the problem.

4.4 Third Party Administrators

There are currently three third party administrator firms in Jordan (Magnet, Mednet, and NatHealth). As of July 1998 they were servicing 74,300[33] people through health plans from insurance companies or self-insured companies. Ten of the 15 insurance companies that reported to the Insurance Controller in July were using TPA services. There is no estimate available for the number of self-insured firms that are using TPAs.

Table 2 summarizes some of the data presented above.

[33] Tally of numbers collected from the three existing TPAs in Jordan. The first TPA told us it has 27,300 subscribers. The second TPA said it has 27,000 subscribers. The third TPA would not give out a number but another TPA estimated the third TPA's number of subscribers at 20,000.

Table 2: Key Information on Private Third Party Payers in Jordan

Variable	Insurance Companies	Third Party Administrators	Self-insured Companies and Associations
Definition	Company that pays medical claims directly for its beneficiaries in exchange for a fixed premium payment	Company that reviews and approves medical claims for payment; negotiates provider networks	Company that pays medical claims directly for its employees or members as a benefit
Number of companies (1998)	20 (licensed) 18 (actually selling)	3	Unknown
Number of companies that use TPAs	10 (17)	n/a	Unknown
Number of beneficiaries covered (1997)	138,815	n/a	Unknown *(Estimated range 390,000-650,000)*
Number of beneficiaries served by TPAs	n/a	74,300	n/a
Weighted Average Cost per beneficiary per year	JD 82 (US$116) average premium for limited coverage, as reported by 17 companies JD 613.3 (US$866) average premium for full coverage, as reported by one company	n/a	JD100.4 (US$142) * for average full coverage, as reported by five companies

Note: Average cost includes medical claims and may also include administrative costs.

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5. Organizational Structure and Business Practices of Third Party Payers

5.1 Benefit Design

Benefit design refers generally to what items are included and excluded from the package of health benefits the insurance company will cover under the policy. Limits to coverage (e.g., cost caps), and cost sharing (e.g., co-payments) are also part of benefits design.

In Jordan, benefit design is the primary method of cost containment and risk control in the private insurance industry. A typical health insurance policy in Jordan will cover physician, hospital and other services but with deductibles, co-payments, limits on the amount for specific services (called “caps”), and exclusions of certain diseases or procedures. This keeps the cost of policies relatively low but has the paradoxical effect of reversing the usual purpose of insurance by providing the most comprehensive coverage for primary care, while providing only minimal coverage for catastrophic care. As a result, benefits may be quickly exhausted if high-cost care is necessary.

Local executives indicated that insurers have tried but failed to sell comprehensive policies in the past. They speculated that consumer disinterest in coverage for catastrophic care may be the perceived high cost of insurance and religious and social beliefs (for example, that death and disease are God’s will) have led consumers to reject more comprehensive coverage. However, at least one major health insurer believes that a demand for more comprehensive coverage does exist and has introduced a new product which more closely resembles traditional full insurance coverage. It is also important to note that many insurance companies often sell several related health insurance products for their clients (such as income maintenance policies) to supplement the health insurance policy. This practice provides broader coverage than is evident in a single health insurance policy because when an individual becomes ill they can collect payments from these related policies to cover expenses excluded by their health insurance policy.

5.1.1 Policy Inclusions and Exclusions

While insurers allow the insured to include or exclude individual benefits, most health insurance policies are relatively standard throughout the insurance industry. Policies have traditionally included physicians' services, emergency care, inpatient and outpatient services, and pharmaceuticals. Also, private insurers often provide coverage for certain kinds of diseases and treatments, such as cancer or renal dialysis, which the government offers for free. Health policies generally exclude dental and mental health coverage, pre-existing conditions, injuries or illness resulting from suicide or acts of war, as well as for numerous disease and care categories (e.g., pregnancy, miscarriage, congenital birth defects, AIDS, alcoholism, Alzheimer’s, and bulimia). Some policies even exclude coverage for treatment of conditions such as hernias, hemorrhoids, and adenoids.

5.1.2 Definition of Beneficiaries

There is a defined range of beneficiaries who may receive coverage under a given policy. While some policies cover only a husband, a wife, and children, others cover the parents of the insured as well as household help, more than one wife and dependent females of any age. Furthermore, in the private sector, coverage often ends when people retire (men at age 60 and women at age 55) and some coverage may be gender-dependent (e.g., an employed male's children will be covered but not an employed female's).

5.1.3 Medical Necessity and Coordination of Benefits

Policies generally include a medical necessity clause that requires, at a minimum, a licensed physician to prescribe the treatment for which payment is claimed. In addition, insurers often require subscribers to seek a pre-admission authorization from the company doctor or their TPA before they can receive elective hospital care.

Insurers do not provide for the coordination of benefits and, in fact, policies often specifically indicate that coverage is provided for "the cost of care not excluding other coverage." It was reported that the lack of such coordination among insurers, the Royal Medical Service and the Ministry of Health creates a situation in which some people receive treatment for the same condition from different systems.

5.2 Underwriting Practices

Underwriting is how insurance companies determine the premiums they will charge subscribers. Underwriting includes estimation of the components the premium is expected to cover such as: a) the medical costs the insurer expects to pay for each subscriber or group of subscribers, based on an analysis of life expectancy and medical care utilization for a group with similar characteristics (age, sex, medical history, etc.), b) the insurer's costs for administering the health policy, c) the level of financial reserves the insurer will need, and d) the profit margin the insurer wants.

Underwriting is both extensive and comprehensive, although reportedly there are no professional health actuaries[34] in Jordan. Given the relatively small size of the industry, underwriting is almost always done on an individual basis using age, sex, and reported medical use. While extensive use of medical underwriting on an individual basis is common, use of sophisticated techniques of determining risk.

As discussed above, setting premiums is highly dependent on restrictive benefit structures and multiple policy limits. In spite of this effort to control medical costs, medical claims are reported to exceed premium revenue at some companies (see in section 4.2.4 the discussion of medical loss ratios) and the health insurance business is not considered to be highly profitable. Health insurance is often sold in concert with life insurance and companies report that they sometimes subsidize health plans to keep or obtain the more lucrative life insurance business.

Policies are offered on both a group and individual basis. Companies do not employ "community rating," in which the insurer charges a group an average premium that assumes that the group is large enough to be representative of the community population as a whole. Instead, they charge based upon the actual medical experience of each group. Also, insurance companies do not knowingly follow cross

[34] Actuaries are specially trained to analyze demographic, morbidity, mortality, and health care utilization data and to calculate the expected costs to insurers for covering different types/groups of subscribers under policies with different benefit designs.

subsidization practices in which, implicitly or explicitly, certain wealthier and/or healthier groups are paying part of the cost for the insurer to cover poorer and/or less healthy people.

5.3 Claims Systems and Capacity

A key function of any third party payer is the review and payment of medical claims. In Jordan, the three newly formed TPAs have the most extensive capacity to handle medical insurance claims systematically, and at least one insurance company reports similar capacity. The TPA systems, two of which were developed and first utilized outside of Jordan, are able to provide the information necessary to support a modern health insurance company, including underwriting, utilization review, pricing, and payment. (None of the TPAs currently pays claims directly but rather authorizes payment to the provider by the insurance company or the employer providing the health benefit plan.) These claims systems are primarily PC-based and handle claims for relatively small groups of people in Jordan. However, the companies indicated that they have the capacity to handle large numbers of people or are already doing so in other countries.

Most health insurance companies in Jordan have relatively simple claims systems that rely on the manual or semi-automated processing of claims. Only a few years ago, the health insurance industry's systems could perform only the most rudimentary health insurance functions. With the assistance of the TPAs, claims capacity is now growing rapidly.

Given the relatively small size of the insurance industry and the small number of skilled employees they employ, it is likely that companies in other sectors like banking have equal or superior systems' capacity. In addition, if these companies are self-insured they may have direct experience with health claims system processing. Although the government's systems capacity was not analyzed, it is unlikely that it possesses much capacity for direct health claims processing given the lack of need.

5.4 Marketing

Marketing functions important to health insurance include research to design health insurance policies that better meet customer needs, sales of health policies that are more complex than other products, and advertising.

Market research does not yet play a significant role in Jordan's health insurance industry. This is not surprising given that health insurance is largely ancillary to life insurance. New products are introduced based upon officials' perceived market needs and from the experiences of associated companies in other Middle Eastern countries If the health insurance market grows, it is likely that more systematic approaches to market research will develop.

Most companies sell their products directly to their clients and/or through insurance brokers. To limit their risk, some companies restrict the number of brokers who can sell health insurance. Many sales are accommodations to existing customers. They engage in little or no advertising since few consider health insurance as a growth industry with the potential for significant profits.

All companies and brokers sell policies to both groups and individuals. Group insurance is largely centered among small or middle size employers. Individual insurance is concentrated among middle and upper class professionals who often work in industries where insurance coverage is not provided. However, some professionals, such as physicians and lawyers, receive coverage through their professional associations. Some insurance companies are reluctant to seek business from the largest companies, which make up the bulk of the self-insured industry, because of the perceived existence of

abuse and fraud in the health insurance programs of these companies. Many well-to-do individuals apparently do not seek health insurance because price controls on health services lead them to believe that medical care is inexpensive relative to the cost of insurance.

5.5 Provider Relations, Contracting, and Management

5.5.1 Contracting

Insurance companies and self-insured firms deal primarily with private sector physicians and hospitals and have used both contractual[35] and indemnification[36] approaches with providers. Contracts with providers are usually simple: they primarily define the terms for payment. Only rarely do they identify other obligations or benefits to either party; one such example this assessment found was a contract between a large insurance company and a hospital, where the company asked the hospital to concentrate its use of pharmaceuticals on locally manufactured medicines. Fundamentally, insurers do not perceive themselves as having incentives to affect provider behavior. They view the medical sector neutrally, as neither in partnership nor in competition with them but as the providers of the services for which they pay.

Recently, TPAs, some self-insured companies, and at least one insurance company have begun to negotiate with limited groups of providers to establish provider networks. The third party payers offer providers technical support, for example information on the most appropriate medical practices, and a high volume of patients, in exchange for lower pricing and more systematic rights to perform utilization review and quality assessment. This is particularly true in the Amman area, where the over-supply of private sector hospital beds and physicians facilitates such activities and agreements. Some insurers have even attempted to contract with parts of the government care system. On the whole, providers do not see such efforts as the means to develop partnerships but rather as a means of securing deeper discounts.

Some self-insured firms maintain their own or contracted primary care organizations and even use them as gatekeepers for referrals to specialty care. No firm indicated that they are considering expansion of these entities into broader group practice organizations, which means that they are unlikely to evolve into a major resource for Universal Health Insurance.

5.5.2 Price Controls

Private third party payers follow government and professional price controls to pay hospitals and physicians. These controls are described below.

Hospital Price Controls

The government has tried to control institutional costs by setting minimum and maximum prices for hospital room and board by type of hospital and class of service (e.g., single, semi-private, ward). The private sector, as represented by the "self-insured company committee," has similar agreements with private sector hospitals. Most prices were established without the benefit of accurate cost data and as early as the 1980s. The basic agreement on hospital fees was established in 1990. The prices are now widely believed to be significantly below actual costs, and some insurers are negotiating even lower prices based upon volume discounts and cost per case method. The lack of real cost information, social

[35] I.e., where insurance companies contract with providers for particular services at specific rates.

[36] I.e., where the insurer pays the subscriber who is receiving health care a fixed amount per disease or per day of the illness and the subscriber is responsible for paying the health provider for any medical costs incurred.

concerns about upsetting the perceived affordability of health care in the country, and the belief that real costs are being controlled may account for the failure to adjust these rates.

In addition, many hospitals suffer from low occupancy (49% among private sector hospitals).[37] Given the two pressures of low prices and low occupancy, there are rumors that the major hospitals in Amman are in serious financial trouble. However, they continue to operate and even acquire sophisticated high-cost technology.

Government hospitals, which operate on a centralized budgeting system, use fee schedules for the relatively rare private sector patients who use their services, or for inter-sector charges between the different government hospital systems. A separate and higher fee schedule exists for non-Jordanian nationals who receive services at public hospitals. In addition, the government sets prices for ancillary services and drugs.

Physician Price Controls

By law, physician fees are set by the Jordanian Medical Association. These fees must be approved by the MOHHC and are presumably subject to the same forces governing the prices of drugs and hospital services. Physicians in the private sector generally bill on a fee-for-service basis, although a few are salaried employees of insurance companies, self-insured firms, and TPAs. Physicians employed by the MOHHC, JUH, and RMS receive salaries based on a schedule determined by each organization.

Price Controls and Cost Containment

Ironically, price controls on health services may be contributing to higher total health care costs in Jordan in the absence of controls on utilization (see "Utilization Review" below). In fact, prices which may be lower than actual costs may put pressure on providers to increase utilization. Low prices also may encourage indiscriminate utilization by patients. Paying providers on a fee-for-service basis may also encourage utilization since the provider earns more for more services delivered. Other potential pressures to increase utilization in Jordan are the over-supply of physicians, excess hospital beds, and the wide availability of new medical technology. While addressing over-utilization is much more difficult than controlling prices, it is important in order to try to contain total costs and to protect patients from unnecessary tests, hospitalizations, and medications. Also, promotion of rational utilization would be important for any social health insurance scheme to avoid a large increase in health expenditures.

5.5.3 Utilization Review

Insurers and TPAs conduct utilization review on an individual case-by-case basis. There does not seem to be any, pattern analysis or review of hospital and physician practice patterns. Standards of care are not evident and reviews of individual cases seem to depend on the reviewer's personal judgment. Much of what is called utilization review is really eligibility or benefits determination. Most reviews focus upon individual hospital admissions. A length of stay is assigned to a patient and the insurer or TPA monitors to make sure the patient does not stay longer than necessary.

Physicians conduct most reviews since they are in greater supply than nurses and can be hired at more affordable wages. Most skills seem to be learned in the workplace as there does not seem to be any professional training programs in utilization review.

Hospitals also can do reviews, often as part of a larger quality assurance program, although such programs do not appear to be a well-developed concept in Jordan and the process of internal review in

[37] 1997 World Bank Health Sector Study, p. 43.

hospitals is informal and at the discretion of the hospital director. The new TPA systems have the capability to do much more sophisticated utilization review in support of quality assurance at hospitals. For example, the TPA system may identify an unusually high rate of infections or cesarean section deliveries in an individual institution and work with the hospital to address the problem. The TPAs indicated they have begun to undertake such activities.

5.5.4 Management Information Systems

In today's world, third party payers need information systems that do more than collect data needed to pay medical claims. A good management information system will also include the collection of data concerning the use, cost, and quality of care. These systems are designed to enable payers to monitor and influence health service delivery for the benefit of their subscribers. Although the need for such systems is widely recognized, existing information systems are rudimentary or non-existent, and few besides the TPAs have done much to develop them. Using their information systems, the TPAs are promising to contain costs in order to acquire insurance company clients and self-insured account business. It is too early to determine whether they can deliver on their promises.

5.5.5 Integrated Health Care Financing and Delivery

An ideal integrated delivery system is structured to coordinate the financing and delivery of services so that it can achieve a high quality of care at a reasonable cost. Approaches such as health maintenance organizations, managed care organizations, or medical service organizations which unite the provision and financing of care, do not presently exist in Jordan. While some insurers may have created their own provider networks or rented the TPA's network, these are largely individual discounting arrangements and do not qualify as health providers working together under common incentives to bring low cost, quality care to their subscribers.

However, at least one private hospital requested and received a proposal from Kaiser International to undertake such a project. In addition, JUH is presently engaged in an experiment with its employees to determine whether, by utilizing their own medical school faculty and prescription control techniques, they can maintain high quality care and contain their costs. Both projects, if pursued further, could evolve into an integrated delivery and financing systems. In addition, the Medical Society has also established an internal committee to determine if it can create a managed care organization for its members and their families.

5.6 Human Resources

Although insurance executives generally seem to be knowledgeable administrators, few are specialists in health insurance. The provider management skills necessary for this kind of insurance are currently lacking. There are no university training programs in insurance and most training is on-the-job. However, the new TPAs (two of which are either owned by or have significant investment from an insurance company) are developing these capacities. Several of the companies are subsidiaries of larger international insurance organizations and have access to expatriate skills. If Jordan's health insurance market were to expand significantly, it would require talents that go far beyond its present capacity, including that of the new TPAs. Some related organizations, such as banks or the Department of Statistics, have staff capabilities that could be converted relatively easily to meet the needs of a health insurance program.

5.7 Government Relations and Industry Associations

Third party payers do not seem to have a coherent government relations strategy to achieve objectives for the health care and health insurance industry as a whole. While negotiating and health service pricing committees exist, the individual companies usually seek changes for themselves. This also is true for health care providers. Thus, despite the extensive government experience of many leaders in the field of private health care, there does not seem to be a regular flow of information between government and industry. Likewise, industry associations (e.g., private hospital association) are not perceived by their members as strong representatives of their views nor as sources of key industry information.

6. Regulatory Environment

The Ministry of Industry and Trade, through its Controller of Insurance, is responsible for the regulation of insurers. Insurance companies in Jordan operate under a general insurance law that lacks significant regulatory authority. Under the general insurance law, insurance companies must annually report insurance premiums collected, claims paid, budget and associated financial statements to the Controller. Health insurance, which is generally coupled with life insurance, accounted for about 12% of total insurance premiums of the JD 96 million collected in Jordan in 1997.

There is little or no coordination between the MOHHC and the Ministry of Industry and Trade concerning the regulation of the health insurance industry. In addition, there is no regulation of self-insured firms' health benefit plans by either ministry.

The Controller's office has put forward new legislation that would increase its responsibilities and strengthen its regulatory authority. The new law would establish an independent commission including key government officials, such as the Minister of Health. A small, high level team would implement the commission's responsibilities, focusing upon areas such as reviewing the solvency of companies and their management capabilities. Under both the present law and the newly drafted legislation, control of regulation is appropriately centered in one organization. Health insurance regulation is a very special area of insurance regulation and, for it to expand, it must have specially trained personnel. Furthermore, there is a natural congruency between health care provider regulation and health insurance regulation, which needs to be encouraged. For example, close cooperation between regulators could resolve more effectively certain certificate-of-need[38] issues. Such cooperation will be essential to the protection of citizens once organizations embodying both health delivery and insurance functions arise.

[38] "Certificate of need" refers to the U.S. practice of requiring organizations to receive approval from a public organization if they want to acquire new expensive medical technology, make significant additions to services, or build new hospital capacity. The idea is to make the applicants show there is a need for additional capacity, within a publicly approved plan, to rationalize the supply of services or capacity.

7. Future Directions of the Private Insurance Market

7.1 Capital Investment Plans

Insurers gave no indication of immediate plans to expand their direct investment in health insurance. However, two insurance companies have made indirect investments through the creation of TPA organizations. One, a major German reinsurer in Jordan, purchased Mednet last year and offers its services to its Jordanian insurance clients. The other, a Jordanian insurer, made a significant capital investment in the Medical Arab German Insurance Network **(**Magnet**)** and also actively markets its new services to its clients. A third, independently funded TPA, NatHealth, indicated that it has already raised more than half of the total capital it needs. Non-Jordanian companies, which operate internationally**,** own several Jordanian insurers and their strategic decisions concerning regional/worldwide participation in health insurance activities could quickly alter local conditions. At least one U.S. managed care company provides technical assistance concerning medical policy to the TPAs. One TPA is working with a major U.S. hospital organization.

The self-insured companies do not apparently plan to change their basic approach to providing benefits to their employees. Some try to control costs by managing health care more effectively, or by reducing benefits. Others are talking about expanding coverage.

7.2 Marketing Plans

7.2.1 Individual Market

Little information is currently available on consumer attitudes towards insurance, although the Partnerships for Health Reform plans to conduct a national household health survey, which will shed light on this issue. The small number of privately insured individuals in Jordan seems to indicate that the industry is far from achieving its potential. One TPA analyzed social security numbers, income, and coverage levels, and estimated the total potential market for private health insurance to be approximately 450,000 people, including the 138,815 people currently covered.

In general, insurance companies did not indicate plans to greatly expand their health insurance markets or products. One exception, as described earlier (section 5.1, “Benefit Design”), is a company that has introduced a full coverage policy at a relatively high premium for which it has high hopes. The early results are promising and, if it is successful, it plans to expand accordingly. This product, which utilizes a provider network, provides medical management and cost controls.

7.2.2 Large Employer Market

One of the major obstacles to the growth of the health insurance industry is the limited sales of group health insurance policies to large companies. Many large companies are already self-insured and believe that health insurance, in its present form, provides little added value. The larger self-insured groups

suggested that the policies offered by insurers are too limited, inflexible, and expensive. For their part, none of the private insurance companies indicated a strong interest in direct marketing to the self-insured companies. They cited concerns about the risks of insuring this population and felt that previous attempts to offer health insurance had been rebuffed.

Certain trends among Jordan's TPAs may open the large employer market to health insurance companies. Private insurance companies have bought or invested in two of the three TPAs. Many self-insured firms are already using or exploring the possibility of using TPAs which would create a link with the insurance companies. The development of provider networks and utilization review by TPAs, if successful, may make the TPAs and private insurers more attractive to large employers. However, changes in attitudes by large employers regarding commercial health insurance is likely to be a prolonged process since large companies often lack a high level of internal coordination and, consequently, information concerning changes in service may travel slowly. In addition, these trends (to buy or invest in TPAs and development of provider networks and utilization review) are being pursued by insurers to contain costs, not to enhance their marketability to large employers specifically.

7.2.3 Government Market

Only one company, a TPA, expressed any interest in government business. It hopes to provide its services to the government as the country moves to some form of universal coverage. Other insurers are either satisfied with their niche or have adopted a wait-and-see attitude towards any future government activity.

8. Involvement of Third Party Payers in a Social Insurance System

The single most important factor determining the role of private third party payers in any country's health sector, is the role of the public sector in the financing and delivery of health services. Globally, the public sector dominates the financing of health care. It is estimated that public health expenditures account for 60% of total health expenditures in the world.[39] The size and roles of private third party payers typically evolve as a response to the gaps in coverage or the perceived deficiencies of the public health system.

Consequently, the immediate task confronting policymakers in Jordan is to define the goals and structure of universal health insurance, specifically addressing: what unmet need for health insurance is trying to be covered?; who will finance coverage (the government, private sources, both); and what is the scope of coverage (catastrophic, comprehensive, essential package)?

Answering these questions requires the government to take into account social policy, such as its economic philosophies and traditions in using the private sector to achieve public goals. It must also consider the relative capacity and resources available in both the public and private sectors. Ultimately, these factors must be blended together based upon an analysis of the political, social, and economic conditions that exist at the time these policy decisions are made.

Jordanian officials have spoken of the importance of private sector participation in a social or universal health insurance system. To date, most discussion has focused on the role of the private providers (hospitals and physicians). A role for third party payers, who are the financiers of care, has received less attention. Insurers and other financiers did not indicate that they had been consulted about participating in future programs.

8.1 Roles of Private Third Party Payers

A review of the private insurance sector in various countries reveals that private insurance has emerged for diverse reasons and its role varies widely. However, three major types of roles for private insurance have been described and are briefly summarized below:[40]

Role 1: Coverage for people who are ineligible for public insurance programs. If publicly financed health insurance is targeted to certain groups (e.g., the poor, the elderly) then private insurance can emerge for segments of the population who are not eligible for public programs. One example is the United States where private insurance has become the primary source of health financing for adults under 65 years of age who are not eligible for Medicaid (for the poor) or Medicare (for the elderly). Private insurance covers 94% of the population in Korea where coverage is compulsory and public insurance is reserved for the very poor.

Role 2: Coverage for people who withdraw from a public insurance program. In some countries with a public health system, people have the option to withdraw and buy private insurance instead. In both

[39] Source: World Development Report 1993.

[40] Chollet, Deborah J. and Lewis, Maureen. "Private Insurance: Principles and Practice" presented at the World Bank Conference "Innovations in Health Care Financing," March 1997.

Chile and Egypt people can withdraw from the public system. In Chile, 27% have private coverage. In Germany, people also may withdraw from the national program of sickness funds financed by a payroll tax; however they may never re-enroll.

Role 3: Supplemental or additional coverage. In many countries with a public health insurance system, people cannot withdraw since they cannot choose to not pay the taxes that finance the public system. However, they may buy private insurance to cover services not covered by the public system or to cover the same services because of perceived deficiencies (e.g., low quality, long waiting times). By law, Canadians can only buy private insurance for services not covered by the public system. In the U.K., people buy private insurance in order to have access to specialist physicians who are not in the National Health System and to "jump the queue." In Brazil and many other Latin American countries, people "pay twice" for health care by paying payroll taxes and private insurance premiums for similar services because public services are seen as low quality.

Table 3 below summaries the discussion above.

Table 3: Major Types of Roles for Private Insurance and Select Country Examples

Role 1: Coverage for people who are ineligible for public insurance programs	Role 2: Coverage for people who choose not to use a public insurance program	Role 3: Supplemental or additional coverage *
U.S.: 71% of pop. under 65	*Chile:* 27% of pop. covered by alternative private insurance (usually employer-sponsored)	*U.K.:* 10% of pop. to access specialists not in the public system or to bypass long waits
Korea: 94% of pop covered by compulsory health insurance system of 400+ autonomous health insurance funds which are subsidized by the government; poorest 6% covered public insurance program.	*Egypt:* 3% of pop. covered by private insurance (usually employer-sponsored) as alternative to Health Insurance Organization	*U.S.:* 33% of pop. over 65 for drugs and other costs not covered by Medicare
	India: 3.3% of pop., mostly the wealthy, provided by employers. Government employees have own system. Both are alternative to publicly funded and operated system.	*Brazil:* 25% of pop., mostly employees of large companies, as alternative to universal health system
	Germany: 9% of pop. withdrawn from national program of sickness funds that are financed by payroll taxes. May never re-enroll.	*Jordan:* 8%–12% of pop, mostly employer based, as alternative to public programs (CIP, RMS, MOHHC)

*Role 3 includes countries where private insurance "supplements" public insurance by covering services not covered by the public system, and countries where private insurance is an "addition" to the public insurance program and covers the same services covered by the public system. In the latter case, often people are paying twice to cover the same services due to perceived deficiencies in the public system.

In considering what role private third party payers might play in Jordan, it is useful to look at the advantages and disadvantages of the private health financing sector in relation to its potential role in a social health insurance system.

8.2 Advantages of the Private Health Financing Sector

It is important to recognize that the advantages depend very much on the market conditions that exist in a given country. Barriers to development of the advantages listed below include over- or under-regulation, capital markets, and policies that impede private investment.

8.2.1 Expertise

In general, insurance executives in Jordan understand insurance principles and know how to administer these programs. However, regardless of the approach chosen to achieve universal coverage, Jordan will need many more individuals skilled in health insurance functions such as underwriting, claims processing, beneficiary services, utilization review, provider payment, and negotiations. The insurance industry, self-insured companies and third party administrators constitute the only existing capacity. Those companies controlled by outside regional and multinational companies have the added advantage of additional technical experts to assist them. Jordan can best increase its supply of trained personnel through domestic educational programs and by utilizing existing private sector expertise.

Alternatives to the domestic insurance industry do exist. For example, it would also be possible to subcontract with international firms to operate all or part of a universal health insurance program and at the same time train new Jordanian professionals. However, such an approach is likely to be more costly and less successful in quickly developing internal capacity.

8.2.2 Flexibility

Private third party payers can often move quickly to acquire the personnel and materials necessary to implement projects rapidly. By paying market salaries, it can employ the most qualified personnel regardless of seniority. Government, with its civil service rules and complex budgeting processes can neither move as quickly as the private sector nor attract the requisite talent. It is often difficult even to make use of the resources of multiple ministries or reach into other industries for needed talent. Given the importance of implementing social insurance rapidly and the scarcity of insurance administration skills in Jordan, the private health financing sector could play a pivotal role. Furthermore, the private sector, which usually operates under contract, can better adapt to the country's changing needs as the program evolves.

8.2.3 Innovation

Although new ideas and experiments do not always arise from private enterprise, the private sector does have more economic incentive to engage in innovation. Not-for-profit as well as profit-making companies have the opportunity to use the revenue gained from successful experimentation to fund other activities and thus accelerate implementation and growth. In other countries, the private sector has developed many new health care financing and delivery techniques that government has subsequently adopted. The Jordanian government might find that such innovations could contribute to its reform efforts.

8.2.4 Capital

If the potential for future profits looks likely, the private sector could provide capital to develop and run the social insurance program. Such investment would depend on the long-term prospects for participation in the program, the alternative uses of capital, and the nature of the program itself. Private capital might also reduce the need for government taxation to initiate the program by spreading the start-up costs over time if private third party payers could include capital costs in their charges to the government.

8.2.5 Credibility

The inclusion of private third party payers in the social insurance program could add credibility to government efforts. Private participation in the implementation of a universal health insurance program may generate support in an important segment of Jordanian society. Such support could even extend beyond the health financing industry itself to include banks, universities, the accounting profession, etc.

8.2.6 Increased Consumer Choice

The presence of a private health financing sector can mean increased choices for consumers for health insurance and providers. Private health insurance may represent an alternative or addition to a public health insurance system.

8.3 Disadvantages of the Private Health Financing Sector

8.3.1 For-profit Nature of the Industry

Private for-profit companies have an obligation to seek the best possible return for their owners and stockholders. Although sophisticated contracting can protect the public interest, the need for returns on investments can be costly and, over time, difficult to justify politically. The current behavior of the insurance industry is instructive. While it plays a necessary role for certain relatively well-to-do segments of society, the industry has little incentive to expand into parts of the market where profits are less certain. This is not to say that the private, for-profit sector has no interest in supporting public goals; indeed, several of the executives we interviewed expressed such a desire.

One way to address this potential disadvantage would be to encourage the formation of private non-profit institutions as an alternative to commercial enterprises. Such institutions can combine the efficiency and other advantages of the for-profit sector with a commitment to pursue certain social objectives. However, non-profit institutions do not currently play a prominent role in the Jordanian health financing sector. Also, it is necessary to regulate such organizations so that they are publicly accountable and do not merely serve the interests of management, boards or special interest groups.

8.3.2 Lack of Private Sector Experience with the Poor

The private sector in many countries has not been particularly successful in dealing with low-income populations. Since, in a social insurance system, it is most important to provide coverage for the disadvantaged, the private sector's lack of experience in dealing with this group of people can significantly reduce the effectiveness of the program. Private sector programs, which are primarily

experienced in dealing with middle income and upper income groups, would need to develop new areas of expertise. There is no reason to believe that, with the proper incentives and government oversight, the private sector could not meet the special challenges of low-income populations.

8.3.3 Tendency to Siphon Off Low-cost People

Private insurers logically seek to insure people who are "low cost," that is, healthy and less likely to use services. Insuring healthy people and denying coverage to sick people can make health insurance more profitable and allow the insurer to charge lower premiums and attract new customers. The disadvantages of this practice for society are that the sick may have reduced access to health insurance, that it reduces cross-subsidization, and that it leaves the government responsible for covering the highest cost people.

8.4 Procurement Approaches

Typically, the role of third party payers in the health sector evolves as a response to public sector programs. Alternatively, policymakers can pro-actively establish a role for private third party payers through procurement approaches wherein the government contracts with the private sector for insurance risk taking, operational, and/or administrative functions. Using procurement approaches, the public sector seeks to harness the advantages and capacities in the private sector. In the United States, where private insurance is most advanced, there are several examples:

- U.S. federal and state governments make a fixed contribution to private insurers, based on the cost of a basic, comprehensive health plan, for their employees. Employees pay additional amounts if they have chosen a plan that provides more extensive services. In addition to paying the fixed contribution, the government establishes requirements for participation, monitors participation and performance, and supervises how individuals join and change insurance plans. These programs cover groups of people larger than the population of Jordan. Regarding the feasibility of doing something similar in Jordan, it should be remembered that when these programs began in the 1960s, the health insurance industry in the United States had greater experience and capacity than the present Jordanian industry.
- When the United States created Medicare (the program for the over-65 population), the government had little capacity to administer a national health care program. Furthermore, the mostly private providers of care so greatly distrusted the government that it was decided to give the responsibility for the administration of the program to private insurers (predominately not-for-profit Blue Cross/Blue Shield Plans) who continue to play that role today. The government supervises the program, establishes policy, and, over the years, has had the flexibility to modify the contractors' responsibility. It is possible to incorporate incentive or risk elements into the administration of the programs in order to provide economic benefits for effective private sector performance.
- The government has recently tried to contract with private insurers and HMOs to provide coverage for groups of people covered Medicare and Medicaid.

In Jordan, the government could shift to private insurers and/or to TPAs the responsibility for paying providers, containing medical costs, ensuring a minimum level of quality, auditing, utilization management, and standards certification. For example, if the new Jordanian TPAs are successful, they could present an important resource with which the government could contract for specific services (e.g., subscriber enrollment, health care utilization review, and maintaining the program's management information systems).

Procurement takes advantage of private sector strengths while providing for direct government oversight. However, procurement approaches require important capacities in both the public and private sectors.

8.4.1 Public Sector Capacity

The procurement approach requires the government to develop new management capacities. Rather than the traditional, centralized decision maker within a controlled organization, the government would act as overall program manager of contracts with the private sector for specific services. To do this, the government must be able to translate policy objectives and programs into clear contracts that spell out requirements and performance standards. The procurement of health care services is far more complex and specialized than the purchase of items such as military equipment, drugs, or janitorial services. It is much more difficult to gauge quality of performance when the customers to be satisfied include the government, providers of care, and recipients. The public sector must also have the capacity for performance monitoring and evaluation, and auditing procedures. Often in other countries, problems have arisen due to the failure of the government to monitor contractors effectively. For policy or privacy reasons, it might be necessary for the public sector to retain responsibility for certain elements of the program, such as determining a minimal benefits package, setting standards of care, and protecting patient confidentiality. The government would also need to avoid abrupt changes in direction that can be costly since contracts are often prospectively negotiated and new contracts often require increased financing. Given Jordan's limited experience contracting with private insurers, the government will require time to develop the needed these skills and structures.

8.4.2 Private Sector Capacity

The private sector must have the capacity to absorb new risks and responsibilities. The insurance industry in Jordan does not currently have the risk capital and administrative capacity to take on a large role. The insurance industry and its supporting institutions would need to commit themselves to investing the necessary time, materials and money to achieve and maintain their new public accountability. Not all companies would necessarily want to or be able to participate in the government program.

In summary, if Jordan decides to pursue using the private sector to achieve social insurance for everyone, it would make sense to move incrementally towards such a strategy so that both the private sector and the Government could prepare themselves for such a system.

8.5 Regulatory Approaches

Regulation is another way that the public sector can determine a role for the private health financing sector in a social insurance system. Similar to most developing countries, there is minimal regulation of private health insurance in Jordan.

Regulations generally aim to maintain a stable insurance market, protect consumers, and/or improve local notions of fairness and equity. The last type of regulatory action is most relevant to social insurance. Since regulation of the health financing sector in Jordan is still beginning, a look at examples of all types of regulations is helpful. Below is an illustrative list of the types of regulations in the key areas mentioned.[41]

[41] Chollet, Deborah J. and Lewis, Maureen. "Private Insurance: Principles and Practice" presented at the World Bank Conference Innovations in Health Care Financing," March 1997.

Stabilize Market:

- Set financial standards for companies to enter market and continue operations through licensure procedures, minimum capital and surplus requirements, restrictions on the type of financial investments that are allowed, required participation in an insolvency guarantee fund that would cover beneficiaries of a bankrupt insurance company.
- Restrictions on market exit through requirements that the insurer notify policyholders of plans to close health insurance business and present plan for paying outstanding claims.
- Requirements to provide reports to the government regulatory agency, including financial statements, an independent actuarial opinion that reserves are adequate relative to the risk assumed by the insurer, independent financial audit.

Protect Consumer:

- Insurance contracts that fully disclose all terms of the insurance policy using common language that policyholders can understand.
- Honest marketing practices.
- System to respond to consumer complaints.

Promote Fairness and Equity:

- Require insurers to use some form of community rating so healthy participants subsidize sick participants.
- Require that rates be reviewed or approved by the government.
- Require that certain services or benefits be included in the policy.

Beyond these standard objectives of regulation, the government could pass legislation that encourages the private insurance sector to have a specific role in a social insurance system, for example, a regulation allowing private insurers to offer supplementary coverage to basic social insurance under certain controlled circumstances, by requiring employers to provide coverage for their employees, and/or by requiring individuals to purchase their own coverage. While regulatory approaches may be less difficult to implement administratively, some can have undesirable economic effects. For example, requiring companies to provide health insurance for their employees can discourage employment or possibly depress wages, since the health benefits are considered compensation. Likewise, one can mandate that individuals have coverage but if it is unaffordable, unavailable, or if there are not effective enforcement mechanisms to see that all have coverage, little is served by such actions. One country, Korea, actually mandates coverage for all of its citizens and 94% of the population are served through 417 autonomous health insurance funds. The government, however, must subsidize these funds in order to make coverage affordable to all.

Mandatory actions, particularly if they are part of a publicly directed program, also require significant regulatory action. The government must at least establish minimum benefits coverage. In the case of mandated benefits, it must define what will be covered, ensure the delivery of these benefits by establishing standards for participating companies or insurers, and acquire the monitoring capacity to ensure that those standards are met. In the case of supplementary coverage, it must establish benefit standards and define which areas will be left to the supplementary carriers. In order to protect the citizens who purchase such supplementary coverage, the government may also want to establish requirements similar to those for mandated coverage.

9. Conclusions and Recommendations

The Jordanian government and private third party payers should explore and develop greater collaboration, not only to support social health insurance but also to exploit opportunities to improve the efficiency, effectiveness, equity, and quality of Jordan's health sector. The private sector is an important political force that can add credibility to government efforts to implement a social health insurance scheme. Also, in many areas of expertise, which are likely to be important for social health insurance, the private sector has the only significant capacity available to the Jordanian government. These capacities include:

- Executive management knowledgeable in insurance practices.
- On-going efforts to develop the skills necessary to operate modern health insurance plans including in-house training programs and the flexibility to secure outside resources through contracts with the emerging TPA market or by tapping expertise from company resources outside Jordan.
- A growing understanding of the techniques used to manage the cost and quality of care through both TPAs and direct action. Examples include:
  - The use of selected provider networks by private insurance companies, third party administrators, and large self-insured companies.
  - The use of utilization management techniques such as pre-hospitalization admission and continuing stay and post-hospitaliztion reviews; medical protocol adoption; and physician best practice techniques in order to control cost and improve the quality of health care (note, however, that these projects are still in their infancy).
  - The use of both foreign and domestically developed computerized systems by private insurance firms as well as TPAs to communicate with hospitals, adjudicate medical claims, and manage cost, utilization, and quality.

To lay the ground for greater collaboration between the Jordanian government and private third party payers, it is important to emphasize issues they have in common. The building of both trust and effective working relationships between the public and private sectors is necessary to prepare the way for future partnerships.

On the positive side:

- There is an understanding among both the public and private sectors that they need each other.
- The government, private insurers, and self-insured companies are all payers of health services and therefore they potentially share the same goals of containing medical costs and improving quality.
- Many in the private sector also share the government's desire to make the country's health sector more equitable and the perception that it needs to be "fixed" before launch of a social insurance system.
- There is unanimous agreement that steps must be taken to change the health delivery system before universal insurance coverage is implemented, irrespective of the role of the private sector.

On the negative side:

- There exists cynicism and mistrust among the public and private sectors towards each other's capacities and motives for reform.
- The public and private sectors have little experience working with each other and both need to be develop critical skills and capacities in order to collaborate successfully.

9.1 Long-Term Recommendations

What needs to be done over the long-term to enable private third party payers to contribute to social health insurance?

1. The Ministry of Industry and Trade must improve its regulation of health insurance if private companies are to play an increased role in providing coverage to all Jordanians. Currently health insurance is regulated only as part of the insurance industry in general. Information on the health insurance sector can only be acquired through special studies. In addition, the Insurance Controller does not have the resources or staff to ensure effective regulation of a more mature and comprehensive health insurance sector involving managed care and provider network contracts. Stronger regulatory laws are required, and there is a need for increased coordination between the health and insurance ministries.

2. Insurers, self-insured companies and key government officials need access to demographic and health-related actuarial information.[42] If the private insurance industry is to begin to provide full-coverage policies, this kind of information must be available in order to accurately project costs. Information about the basic costs of health services (by diagnosis, health facility, and other meaningful categories) should also be available for both public and private hospitals to enable them to negotiate contracts with payers, which make sense financially.

3. There is an important need for new management techniques if the public sector is going to manage a public-private sector partnership for universal health insurance coverage. Coordination between regulators and policymakers in government health and insurance organizations is mandatory if the private sector is to be given the right incentives and led to meet public goals through enlightened self-interest. This recommended approach would take into consideration the assets and needs of both the public and private sectors and the mutual benefits to be attained through a collaborative effort.

4. The following limitations of the private health insurance companies would need to addressed, or at least acknowledged, in developing options for their involvement in social health insurance:

    - The size of the industry is small (approximately JD 10.6 ($15.0) million a year in premium revenue) and several of the companies selling health insurance reported that they did not make a profit on health insurance in 1997.
    - Operational system capacities are limited, and it would take a substantial investment of time and energy to enable them to handle a significant portion of Jordan's 4.6 million population.
    - There is little or no experience in dealing with government health facilities.

[42] For example, information by age, sex, geography, high risk behavior, illness, and medical care use.

- Heath insurance is seen as complimentary to life insurance and is often sold only as a courtesy to customers who purchase other types of insurance.
- The industry is risk-adverse. Much of their enrollment is in plans designed to limit enrollment to good risks or limit benefits for high-cost medical care. This tends to provide insurance coverage only for simple or minor ambulatory services and is contrary to a basic purpose of insurance, which is to provide coverage for the high cost medical care.

Organizationally all of Jordan's major private health insurance companies and hospitals are for-profit institutions. This approach to health financing and delivery has both advantages and disadvantages. Given the small size of the health insurance industry and moderate size of the hospital industry, it would be worthwhile for the government to experiment with not-for-profit approaches to gauge the possible differences between them and the existing for-profit institutions.

9.2 Short-Term Recommendations

The government can take some immediate steps to determine what roles private insurance might play. These steps would prove useful even if it is decided ultimately to minimize the role of the insurance sector in the program:

1. Step up interaction between government and private sector experts in the fields of health and insurance. They should establish joint working parties to address specific issues and attempt to identify areas of expertise and understanding of purpose.

2. Work on improving insurance regulations in order to make the private insurance sector and associated companies such as TPAs more accountable to their subscribers.

3. Undertake joint projects in specific areas to learn how public/private partnerships could work. Such projects might include developing performance standards and utilizing the private sector to provide coverage to a small group of people, or using TPAs to provide utilization management services under government supervision for a selected population.

4. Support the establishment (preferably jointly with the private sector) of insurance training programs that would focus on developing skills in: a) the principles of (health) insurance, b) the contract management of health programs, and c) health sector actuarial work. Initially this may require some training abroad but ultimately it should be developed within Jordan.